EMPLOYEE BENEFITS APPLICATION
State Form 53389 (R2 / 10-10)
INDIANA STATE PERSONNEL DEPARTMENT

Open Enrollment 2011

(Please Print)

Select Your Enrollment Type: ○ New Hire ○ Qualifying Event/Status Change

Name: _____ Phone: _____

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐ Employee ID: 10000☐☐☐☐☐☐

Date of Hire/Event: ☐☐ - ☐☐ - ☐☐ Agency Business Unit: ☐☐☐☐☐

For new hires, elections must be made by the Monday following the pay period in which you were hired. Other changes must be submitted within 30 days of the qualifying event.

Dependent Information

- If a dependent is 26 or over, incapable of self-sustaining employment as a result of a mental or physical disability, and is chiefly dependent upon the employee for support and maintenance, certification of the incapacity prior to age 19 and proof of prior coverage must be submitted with this form.
- If a dependent is not living with the employee, please provide the dependent's address on the back of this form.

Add	Drop	Name / Social Security Number	Date of Birth (mm/dd/yy) / Gender / Marital Status	Relationship / Student/ Disabled	Health	Dental	Vision	HMO Provider number (if applicable)
●	○	*John Doe* *1 2 3 4 5 6 7 8 9*	*1 0 0 3 5 6* *(M) F S (M) D*	*Spouse*	●	●	●	*123456*
○	○		M F S M D		○	○	○	
○	○		M F S M D		○	○	○	
○	○		M F S M D		○	○	○	
○	○		M F S M D		○	○	○	
○	○		M F S M D		○	○	○	
○	○		M F S M D		○	○	○	

TAXSAVER

You will automatically be enrolled in TAXSAVER for all eligible benefits. TAXSAVER is a program where insurance contributions are deducted from your gross pay prior to taxes. Taxes are calculated on lower pay resulting in more take home pay. This is not a tax deferral, but a permanent tax reduction for as long as you participate. If you would like to opt out of the TAXSAVER program, indicate that by writing "NO TAXSAVER" on the top of this form.

Health Insurance

IMPORTANT NOTES before you make your election:

- With the **Consumer Driven Health Plans**, you **must open a Health Savings Account** with Tower Bank to receive the State's contribution. Please complete an online application by going to www.hsa.towerbank.net to open an HSA. The first page of this online session says: If you have been instructed by your employer to visit this site to open your Health Savings Account, click this button and insert your employer code below. Enter 100366 in the "employer code" and it will begin the state application. You will need the following information to complete the HSA Application online: (1) Driver's license; (2) Social Security number, date of birth and address for your beneficiaries; (3) Social Security number, date of birth and address for your authorized signer (if selected); and (4) security passwords for you and your authorized signer.

- **If you elect to receive Social Security Benefits, at age 62 or later, you will automatically be enrolled in Medicare Part A when you turn age 65 and will not be able to participate in an HSA. If you enroll in Medicare, with or without receiving the Social Security Benefits, you may not participate in an HSA.** Due to the enrollment in Medicare Part A only or Part A & B, participants are no longer eligible to receive the State's contribution or make their own contributions into a health savings account.

○ **I DECLINE HEALTH INSURANCE**

○ Consumer Driven Health Plan 1 ○ Single ○ Family

○ Health Savings Account w/ CDHP 1

To elect the HSA & receive the State's contribution, place a check mark next to the HSA circle above. If you want to contribute in addition to the State's portion, fill in the Bi-Weekly or Annual contribution fields.

Bi-Weekly Employee Contribution: $☐☐☐☐.☐☐

Annual Employee Contribution: $☐☐☐☐.☐☐

○ Consumer Driven Health Plan 2 ○ Single ○ Family

○ Health Savings Account w/ CDHP 2

To elect the HSA & receive the State's contribution, place a check mark next to the HSA circle above. If you want to contribute in addition to the State's portion, fill in the Bi-Weekly or Annual contribution fields.

Bi-Weekly Employee Contribution: $☐☐☐☐.☐☐

Annual Employee Contribution: $☐☐☐☐.☐☐

○ Traditional PPO ○ Single ○ Family

Dental Insurance

○ **I DECLINE DENTAL INSURANCE**

○ Delta Dental Plan ○ Single ○ Family

Vision Insurance

○ **I DECLINE VISION INSURANCE**

○ Anthem Blue View Vision Select ○ Single ○ Family

Flexible Spending Accounts

- Flexible Spending Accounts allow you to set aside money prior to withholding taxes for reimbursement of qualified medical and/or dependent care expenses.
- There is $2.00 bi-weekly administrative fee to participate.
- You must re-enroll each year, participation does not continue automatically.
- Monies not used prior to the end of the grace period each year will be forfeited.
- Individuals electing the Consumer Driven Health Plans with an HSA are subject to the Limited Scope Reimbursement Provision for the Medical Flexible Spending Account.
- The bi-weekly contribution should be calculated by dividing the annual election by the remaining pay periods and then rounding up to the next penny.

○ **I DECLINE FLEXIBLE SPENDING ACCOUNTS**

○ Medical Flexible Spending Account
Bi-Weekly Employee Contribution: $☐☐☐☐.☐☐
Annual Employee Contribution: $☐☐☐☐.☐☐

○ Dependent Care Flexible Spending Account
Bi-Weekly Employee Contribution: $☐☐☐☐.☐☐
Annual Employee Contribution: $☐☐☐☐.☐☐

Basic Life and AD&D Insurance

If you wish to apply for Basic Life and AD&D Insurance Coverage, please fill in the circle below. **Not marking the circle will be considered a declination of this coverage.**

○ I hereby apply for Basic Life Insurance and AD&D Insurance Coverage

- Eligible individuals who do not apply for coverage during their initial enrollment periods may only apply during an annual enrollment period and are first required to submit Evidence of Insurability, undergo medical underwriting, and receive approval from American United Life Insurance Company® (AUL), a OneAmerica® company before any coverage will exist.

- The amount of basic life and AD&D insurance coverage is equal to your annual salary rounded up to the next $1,000 multiplied by 150%. The amount of coverage will automatically change according to salary changes.

Name of Primary Beneficiary	Relationship	Social Security Number Date of Birth *(mm/dd/yy)*	Percentage *(total must = 100%)*
Name of Contingent Beneficiary	**Relationship**	**Social Security Number Date of Birth *(mm/dd/yy)***	**Percentage *(total must = 100%)***

Supplemental Life Insurance

Individuals must first select basic life insurance coverage in order to apply and be approved for supplemental life insurance. You may apply for supplemental life insurance coverage in increments of $10,000 up to a maximum of $150,000. **NOTE:** Upon reaching age 65, any amount of coverage in excess of $100,000 will automatically reduce to $100,000.

If you wish to apply for Supplemental Life Insurance Coverage, please select an amount below. **Not selecting an amount will be considered a declination of this coverage.**

○ $10,000	○ $40,000	○ $70,000	○ $100,000	○ $130,000
○ $20,000	○ $50,000	○ $80,000	○ $110,000	○ $140,000
○ $30,000	○ $60,000	○ $90,000	○ $120,000	○ $150,000

Name of Primary Beneficiary	Relationship	Social Security Number Date of Birth *(mm/dd/yy)*	Percentage *(total must = 100%)*
Name of Contingent Beneficiary	**Relationship**	**Social Security Number Date of Birth *(mm/dd/yy)***	**Percentage *(total must = 100%)***

Dependent Life Insurance

Individuals must first select basic and supplemental life insurance in order to apply and be approved for dependent life insurance.

Dependents can include an employee's a) legal spouse; b) child, step-child, foster child, or adopted child of the employee or spouse, or any child who resides in the home for whom the employee or spouse has been appointed legal guardian, under the age of 26; or c) child who is incapable of self-sustaining employment as a result of mental or physical disability and is chiefly dependent upon the employee for support and maintenance. The child must have been incapacitated prior to age 19 and while insured as a Dependent under the group life insurance policy.

If you wish to apply for Dependent Life Insurance Coverage, please select only ***one*** of the options below. **Not selecting an option or selecting more than one option will be considered a declination of this coverage.**

Spouse Only	Child(ren) Only	Spouse & Child(ren)
○ $5,000	○ $5,000	○ $5,000
○ $10,000	○ $10,000	○ $10,000
○ $15,000	○ $15,000	○ $15,000

- I hereby apply for the group insurance coverage for which I and my dependents listed above, if any, are eligible and available under the policies issued to the State of Indiana. I understand receipt of any coverage greater than the guaranteed issue amount or application for coverage after the approved enrollment period first requires medical underwriting and written approval by the insurance carrier.
- I authorize the State of Indiana to deduct from my wages the amount of premium required for the amount of coverage approved by the insurance carrier, including any premium increases due to age bracket or salary changes when applicable. Premium payments greater than the amount of premium owed will not result in additional coverage under the insurance policy(ies).
- The undersigned represents any information or documents provided to the insurance carrier by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees 1. Any insurance coverage or benefits are contingent upon any statements made to the insurance carrier as being complete and correct and 2. Benefits under any policy will be paid only if the insurance carrier decides in its discretion the applicant is entitled to them. The undersigned have read, understand, and retained the notices, limitations and exclusions for his/her records.
- The undersigned understands life insurance coverages contain a Suicide Limitation which states: If a person commits suicide, while sane or insane, (1) within two (2) years from the later of January 1, 2006 or the effective date of Personal Insurance, the benefits payable will be limited to the premiums paid; or (2) two (2) or more years after the effective date of Personal Insurance, but within two (2) years of the effective date of an increase in the amount of coverage previously obtained, the benefits payable will be limited to the coverage obtained prior to the effective date of the increase, if any, plus the premiums paid for the increased coverage.
- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Signature of Employee: _____ **Date** ***(mm/dd/yy)*****:** _____

For Office Use Only

PS Changes Entered ☐	AS 47 Form ☐	Disabled Form ☐	Supporting Documentation ☐ *(If required)*	Initial COBRA Notification ☐